

## As the health divide widens in Sweden and Britain, what's happening to access to care?

Margaret Whitehead, Maria Evandrou, Bengt Haglund, Finn Diderichsen

**This is the last of three articles reflecting on recent developments in healthcare policy in Sweden**

Department of Public Health Sciences, Karolinska Institute, S-172 83 Sundbyberg, Sweden

Margaret Whitehead, *visiting fellow*

Finn Diderichsen, *professor*

King's Fund Policy Institute, London W1M 0AN

Maria Evandrou, *visiting fellow*

Centre for Epidemiology, National Board of Health and Welfare, Stockholm, Sweden  
Bengt Haglund, *associate professor*

Correspondence to: Professor M Whitehead, The Old School, Ash Magna, Whitchurch, Shropshire SY13 4DR  
margaret@ashmagna.demon.co.uk

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In both Sweden and Britain, social inequalities in health have been widening over the past 20 years. In Sweden, improvement in life expectancy weighted for health has been greater for men and women in non-manual than in manual occupations.<sup>1</sup> Swedish industrial workers experienced increasing mortality in the 1970s and early 1980s, at a time when death rates among professional and managerial workers were decreasing sharply.<sup>2</sup>

Likewise in Britain, large and widening differentials in mortality have been reported between the most and the least deprived areas in Scotland and northern England.<sup>3,4</sup> At a national level, the gap between the death rates of different social classes has also widened over the 1980s and up to 1993.<sup>5,6</sup> Mortality is now three times higher in unskilled manual workers than among professionals.<sup>6</sup> Large differentials in morbidity have also been found.<sup>7,8</sup>

### The role of equitable health services

Lack of access to essential health care is likely to make only a minor contribution to the overall difference in mortality.<sup>9</sup> Nevertheless, health services have an important role, not least in coping with and ameliorating the damage to health caused by inequalities in society. At times of growing inequalities in health, it is more important than ever to ensure equitable access to health care for those hardest hit.<sup>10,11</sup>

In this respect, both Sweden and Britain have prided themselves on their national health services, based on equal access for equal need. Swedish evidence from the 1970s and 1980s supported the claim of an equitable service. After health status was controlled for, no socioeconomic differences were found in the proportion who had visited a doctor<sup>12,13</sup>; whereas studies from the 1960s (before user fees were reduced in a major health policy reform) had found higher use of the health service among high income groups.<sup>14</sup>

In Britain, the argument has shifted over time, with early evidence indicating a "pro-rich" bias<sup>15,16</sup> whereas later studies concluded that, in primary care at least, there was a "pro-poor" bias.<sup>17-19</sup> However, most of these studies were based on data from the 1970s and 1980s, and it is not clear if the situation has changed since then.

### Analysing the current situation

To assess what has been happening to access and uptake of health care in the two countries over this period of

### Summary points

In 1993-4, inequalities in access to care appeared in Sweden for the first time since the 1960s

Britain had little socioeconomic inequality in consultations with general practitioners in the mid-1980s, but a "pro-poor" gradient developed in the 1990s; this was not apparent for outpatient visits

In both countries the health divide widened between socioeconomic groups between 1984-5 and 1990-1 and narrowed slightly by 1993-4

This narrowing of health differentials in Britain occurred because of a marked deterioration in morbidity for the professional group

The major shifts in labour market and health policies over the decade provide possible explanations for some of the trends in utilisation

widening inequalities in health, we used the British general household survey and Swedish survey of living conditions to analyse prevalence of ill health and use of the health service among different socioeconomic groups over three periods between 1984 and 1994. Two calendar years of data were aggregated for each period.

Five fairly comparable socioeconomic groups were constructed for each country. They were based on Sweden's socioeconomic classification and Britain's socioeconomic grouping. In both countries, the socioeconomic groups included all people who were currently employed, as well as unemployed people and the "economically inactive," provided they had previously been employed. This is important because of the increasing numbers moving out of the labour force.<sup>20</sup> The main difference in the classifications is that the British scheme incorporates self employed people into the socioeconomic group with employees of the same occupation, whereas the Swedish classification does not.

Utilisation of the health service was used as a proxy for access to care. Multivariate logistic regression was used to calculate, for each socioeconomic group, the odds ratios for consulting a doctor, adjusted for demographic factors (age, sex, and marital status), a measure

**Table 1** Trends in use of health service, Sweden, 1984-94

| Socioeconomic group | 1984-85           |                      | 1990-91           |                      | 1993-94           |                      |
|---------------------|-------------------|----------------------|-------------------|----------------------|-------------------|----------------------|
|                     | % Visiting doctor | Odds ratio (95% CI)* | % Visiting doctor | Odds ratio (95% CI)* | % Visiting doctor | Odds ratio (95% CI)* |
| Professional        | 27.1              | 1.00                 | 28.8              | 1.00                 | 34.9              | 1.00                 |
| Intermediate        | 31.8              | 1.19 (0.98 to 1.43)  | 30.8              | 1.02 (0.85 to 1.23)  | 34.4              | 0.87 (0.73 to 1.03)  |
| Lower non-manual    | 36.4              | 1.24 (1.03 to 1.50)  | 34.8              | 1.03 (0.85 to 1.24)  | 37.7              | 0.85 (0.71 to 1.01)  |
| Skilled manual      | 34.7              | 1.11 (0.92 to 1.34)  | 34.8              | 0.92 (0.76 to 1.12)  | 36.8              | 0.82 (0.69 to 0.98)  |
| Unskilled manual    | 38.3              | 1.13 (0.94 to 1.34)  | 39.7              | 0.97 (0.82 to 1.16)  | 38.8              | 0.73 (0.62 to 0.87)  |

\*Adjusted for age, sex, marital status, region and health status.

of supply (metropolitan and non-metropolitan areas), and the major confounder of health status (model 1). The health status adjustment combined survey responses on self reported general health, longstanding illness, and limiting longstanding illness.

In a second multivariate logistic regression (model 2), employment status (divided into employed, unemployed, and economically inactive) was added to the first model to test whether employment situation was an important mechanism through which socioeconomic status influenced use of health care.

To study the trends in morbidity over the same periods, prevalence rates standardised for age and sex were calculated for the various measures of health status for each socioeconomic group.

## Swedish developments

Table 1 shows that in Sweden the proportion of each socioeconomic group visiting a doctor increased over the decade 1984-94. The increase was particularly strong for professionals in the 1990s—their consultations were approaching the level of manual groups by 1993-4.

Lower use in relation to health status among manual workers had developed by 1993-4. Adding employment status to the model did not change the estimates for socioeconomic groups, not even when long term unemployment became prevalent in Sweden in the 1990s.

Are these emerging inequalities in use accompanied by growing inequalities in morbidity? Table 2 shows clear inequalities in the prevalence of fair or poor health, ranging from 16% in professionals to 29% in unskilled manual workers in 1984-5. These inequalities widened in 1990-1, then narrowed slightly in 1993-4 with an increased prevalence of fair or poor health among professional and intermediate groups.

## British developments

A corresponding analysis for Britain, combining general practitioner and outpatient visits, showed little inequality in access to care (table 3).

In Britain, general practitioner consultations can be separated from outpatient visits. This resulted in distinct gradients in use (table 4). Little inequality in NHS consultations with general practitioners was apparent in the mid-1980s, but a gradient favouring manual groups had developed by the beginning of the 1990s and was maintained in 1993-4. In contrast, for outpatient visits there was a (non-significant) gradient favouring professionals in the 1980s (table 4).

Trends in morbidity in Britain show a clear socioeconomic gradient in health within each period (table 5). By 1993-4 the proportion reporting fair or poor health ranged from 27% of professionals to 47% of the unskilled manual group. Over the decade, the British differentials in morbidity widened, then

**Table 2** Respondents reporting fair or poor health, Sweden, 1984-94. Values are percentages (95% confidence intervals), standardised for age and sex

| Socioeconomic group | 1984-5              | 1990-1              | 1993-4              |
|---------------------|---------------------|---------------------|---------------------|
| Professional        | 16.0 (13.9 to 18.1) | 14.4 (12.3 to 16.4) | 16.1 (14.0 to 18.2) |
| Intermediate        | 14.4 (12.8 to 16.1) | 15.9 (14.1 to 17.8) | 18.5 (16.7 to 20.4) |
| Lower non-manual    | 19.3 (17.3 to 21.3) | 20.2 (18.0 to 22.4) | 22.4 (20.2 to 24.6) |
| Skilled manual      | 26.7 (24.4 to 29.0) | 30.6 (28.3 to 33.0) | 29.0 (26.7 to 31.3) |
| Unskilled manual    | 29.2 (27.6 to 30.9) | 32.6 (30.2 to 35.0) | 32.9 (30.7 to 35.0) |

narrowed slightly in the latest period as a result of a strong increase in morbidity in the professional group during the 1990s. This was also found for longstanding illness and limiting longstanding illness.

## Comparisons between countries

The increase in reported morbidity in non-manual groups in 1993-4 was apparent in both countries, though more marked among professionals in Britain, and was consistent for all the health indicators examined. In both countries the health gap between socioeconomic groups widened from 1984-5 to 1990-1, and then narrowed slightly up to 1993-4.

Where the countries differ strikingly is in the trends in access to care. For Sweden, inequalities in use of the health service appeared in 1993-4, favouring the professional group. This was due partly to a substantial

**Table 3** Trends in use of health service, Great Britain, 1984-94

| Socioeconomic group | 1984-5                           |                      | 1990-1                           |                      | 1993-4                           |                      |
|---------------------|----------------------------------|----------------------|----------------------------------|----------------------|----------------------------------|----------------------|
|                     | % Visiting doctor or outpatients | Odds ratio (95% CI)* | % Visiting doctor or outpatients | Odds ratio (95% CI)* | % Visiting doctor or outpatients | Odds ratio (95% CI)* |
| Professional        | 16.6                             | 1.00                 | 16.1                             | 1.00                 | 18.7                             | 1.00                 |
| Intermediate        | 20.5                             | 1.10 (0.90 to 1.33)  | 21.1                             | 1.15 (0.97 to 1.37)  | 22.8                             | 1.13 (0.96 to 1.33)  |
| Lower non-manual    | 22.9                             | 1.07 (0.89 to 1.28)  | 25.4                             | 1.24 (1.05 to 1.47)  | 26.6                             | 1.17 (1.00 to 1.37)  |
| Skilled manual      | 22.2                             | 1.03 (0.86 to 1.25)  | 23.2                             | 1.12 (0.95 to 1.33)  | 25.9                             | 1.15 (0.98 to 1.36)  |
| Unskilled manual    | 24.8                             | 0.98 (0.81 to 1.18)  | 27.1                             | 1.10 (0.93 to 1.30)  | 28.1                             | 1.07 (0.91 to 1.26)  |

\*Adjusted for age, sex, marital status, region, and health status.

**Table 4** Odds ratios\* (95% confidence intervals) for consultations with general practitioners and outpatient visits, Great Britain, 1984-94

| Socioeconomic group                             | 1984-5              | 1990-1              | 1993-4              |
|-------------------------------------------------|---------------------|---------------------|---------------------|
| <b>Consultations with general practitioners</b> |                     |                     |                     |
| Professional                                    | 1.00                | 1.00                | 1.00                |
| Intermediate                                    | 1.13 (0.87 to 1.46) | 1.34 (1.05 to 1.70) | 1.27 (1.02 to 1.59) |
| Lower non-manual                                | 1.08 (0.84 to 1.39) | 1.35 (1.07 to 1.70) | 1.40 (1.13 to 1.74) |
| Skilled manual                                  | 1.05 (0.82 to 1.36) | 1.33 (1.05 to 1.67) | 1.36 (1.09 to 1.68) |
| Unskilled manual                                | 1.07 (0.83 to 1.37) | 1.36 (1.08 to 1.72) | 1.41 (1.13 to 1.75) |
| <b>Outpatient visits</b>                        |                     |                     |                     |
| Professional                                    | 1.00                | 1.00                | 1.00                |
| Intermediate                                    | 0.94 (0.74 to 1.18) | 1.03 (0.83 to 1.27) | 1.08 (0.88 to 1.31) |
| Lower non-manual                                | 0.95 (0.76 to 1.19) | 1.18 (0.96 to 1.44) | 1.07 (0.88 to 1.30) |
| Skilled manual                                  | 0.93 (0.75 to 1.16) | 1.03 (0.84 to 1.27) | 1.06 (0.87 to 1.28) |
| Unskilled manual                                | 0.85 (0.68 to 1.06) | 1.02 (0.83 to 1.25) | 0.93 (0.77 to 1.14) |

\*Adjusted for age, marital status, region, and health status.

**Table 5** Respondents reporting fair or poor health, Great Britain, 1984-94. Values are percentages (95% confidence intervals), standardised for age and sex

| Socioeconomic group | 1984-5              | 1990-1              | 1993-4              |
|---------------------|---------------------|---------------------|---------------------|
| Professional        | 21.8 (16.0 to 27.3) | 19.3 (15.6 to 22.7) | 27.2 (22.4 to 31.5) |
| Intermediate        | 29.0 (26.9 to 31.0) | 31.0 (28.9 to 32.8) | 31.7 (29.5 to 33.2) |
| Lower non-manual    | 31.6 (30.2 to 32.9) | 32.1 (30.6 to 33.3) | 35.0 (33.4 to 36.2) |
| Skilled manual      | 40.0 (37.9 to 42.0) | 42.8 (40.3 to 44.6) | 41.6 (39.1 to 43.4) |
| Unskilled manual    | 45.2 (43.5 to 46.7) | 47.0 (45.0 to 48.4) | 47.2 (45.1 to 48.7) |

increase in utilisation among professionals and partly to increasing inequalities in reported health. In Britain, differentials in utilisation between socioeconomic groups in all three periods were negligible when the measure of access was reasonably comparable with that available in Sweden (general practitioner and outpatient visits combined).

When we disaggregated utilisation, further contrasts became apparent. In Britain, trends in general practitioner consultations showed, as in Sweden, the development of inequalities in use during the 1990s, but unlike in Sweden, these favoured manual groups. There was a slight, non-significant, bias in favour of professionals in outpatient visits in the mid-1980s, but this bias had disappeared by the 1990s: the mirror image of developments in Sweden.

## Possible explanations

### Market reforms

Traditionally, the Swedish healthcare system has relied heavily on hospital services. In the past decade, market related reforms have included attempts to expand the number of private and public physicians in primary care.<sup>21-22</sup> Many of these reforms were introduced in response to discontent among middle class sections of the population, and the way the changes were designed may have facilitated access of professional groups to these services, over and above other groups.

### Spending cuts

Tight cost control measures have been in operation in the Swedish health service since the early 1980s, and these became much more stringent in response to the worsening economic situation from 1991 onwards. Spending per capita is now only about 10% higher than in Britain.<sup>23</sup> This has the dual effect of reducing the level or quality of services available to the general

population and producing high unemployment among health service workers, both of which may hit lower paid workers the hardest. British spending on health care has been low by international standards and has risen only modestly,<sup>24</sup> but cuts have not been as rapid and severe as in Sweden.

### Increased user charges

Lower paid workers would also be expected to be hardest hit by the sharp increases in Swedish user charges. The flat rate charge for every general practitioner or outpatient visit, as well as charges per day in hospital and for drugs, have increased gradually since the early 1970s and rose sharply in 1996-7. The combination of increased charges and higher unemployment may deter lower income groups from using the service. The British NHS does not currently have user charges for general practitioner or outpatient services.

### Unemployment and privatisation of occupational health services

In the 1990s occupational health services have experienced cuts and privatisation. In Sweden occupational health services provide primary health care, particularly for manual workers, the groups showing a relative decline in use of the health service. From 1992, unemployment increased greatly in Sweden, especially among manual workers; the reduced use of the health service by people not in employment may indicate growing barriers to access to occupationally based services. However, we found no evidence that employment status accounted for the changing pattern of health service use in manual groups.

### "Pro-poor" bias in Britain

The opposite trend, a bias favouring lower socioeconomic groups in access to general practitioner services developing in Britain over the decade, could be seen as part of a longer term transition. Studies in the 1970s found a bias in favour of richer groups in the NHS and were influential in generating debate about inequalities in service provision.<sup>15-25</sup> Since then the NHS, at least at the general practice level, may have been putting more effort into providing services for less advantaged socioeconomic groups. Other studies using the general household survey reported a bias in favour of poorer groups in the NHS in the late 1980s and early 1990s.<sup>17-18-26</sup> Our analysis is the first to span several points in time and to pick up a transitional phase.

The conclusions from this study only apply to access to specific primary care and outpatient services; the measures used would not pick up possible differentials in the quality of services. British women and elderly people, and people experiencing social disadvantage, have been found to have poorer access to specialist diagnostic and inpatient services.<sup>27-28</sup>

In times of growing hardship, accompanied by increasing inequalities in health, it is important to question how well the health sector is responding. This analysis provides an early indication of possible problems with access to care in Sweden developing in the 1990s. It also raises wider concerns about British trends in the health of different socioeconomic groups. Both are crucial areas for further investigation.

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## Personal paper:

# The conflict in transferring a cystic fibrosis specialist service between two hospitals in Manchester

A K Webb, S P Hanley

Despite the best endeavours of doctors and managers when faced with a turbulent mixture of vested interests—local politics, competing trusts, university, and patients—there is still no easy path to tread when moving specialist services between NHS trusts. In 1993 a proposal to move the regional adult cystic fibrosis unit for the north west of England from within what is now the North Manchester Hospitals NHS Trust to one in the south of the city was opposed by the health authority in North Manchester. There was no effective arbitration process available to resolve the issue between the factions in the competitive climate promoted by the NHS reforms. In this “tale of two hospitals” we describe the tumultuous sequence of events that eventually culminated in the move.

## Relocation of the adult cystic fibrosis unit

During early 1992 it was proposed that the regional cystic fibrosis unit should be transferred from a small peripheral hospital to the district general hospital (North Manchester General). In mid-year, the new accommodation offered to the unit was withdrawn because of a funding shortfall of £200 000. Consequently, the unit's two respiratory physicians (AKW and

## Summary points

In 1993 the regional adult cystic fibrosis centre for the north west of England was transferred from the Monsall hospital, part of the North Manchester Health Authority, to the Wythenshaw Hospital, part of the South Manchester Health Authority

The move had been vigorously opposed by North Manchester, and the resulting conflict between hospitals had a seriously demoralising effect on both unit staff and patients

The regional health authority had no power, it seemed, and the purchasers were unable to organise themselves in order to resolve the issue

Despite the competitive climate promoted by the NHS reforms and the fact that this is not an isolated incident, the NHS has no effective process for arbitrating between opposing groups, except by resorting to judicial or ministerial review

Bradbury Cystic Fibrosis Unit, North West Lung Centre, Wythenshaw Hospital, Manchester M23 9LT

A K Webb, consultant respiratory physician

North Manchester Health Authority, Manchester M8 5RB

S P Hanley, consultant general respiratory physician

Correspondence to: Dr Webb

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The new Bradbury Cystic Fibrosis Unit—a charitable grant for its building was nearly lost because of the dispute between hospitals

SH) approached the regional health authority for extra funding for these facilities. The authority suggested that the unit relocate and integrate with the regional cardiorespiratory services based at Wythenshawe Hospital, part of South Manchester Health Authority. The medical appropriateness of this move was universally accepted by all parties in the subsequent discussions.

AKW approached the physicians and management of Wythenshawe Hospital, who agreed to accept the unit. No formal transfer was discussed at this time between the two boards. In November 1992 AKW advised the chief executive of the North Manchester Hospital about the proposed move to Wythenshawe Hospital and no objections were raised.

In early 1993, a working party was established by South Manchester to organise the transfer of the unit staff, the 145 patients, and the assets. The charitable assets of the unit comprised £70 000 held in endowment funds and equipment worth £150 000. The unit, together with the chairman and fundraiser of the Cystic Fibrosis Trust, had applied in 1992 to a charitable foundation based in Hong Kong for a capital grant of £800 000. The grant proposal was accepted in March 1993 with two conditions: the money was to be used for a building for patients attending the unit (wherever it was located), and the building work should begin by September 1993 or the funding would be withdrawn.

### Conflict and consequences

In June 1993 a consultation document from the North Manchester General Hospital supported the proposed transfer, although there had been no formal discussion between the two sides or clarification with the purchasers. Nor had approval been sought from the community health councils. But unexpectedly in July 1993 North Manchester opposed the move to South Manchester, stating that if the unit left, remaining fixed costs amounting to £300 000 would have to be passed on to the purchasers.

Despite much discussion the situation remained unresolved. On 21 July 1993 a formal meeting took place between the two chief executives and their respective teams from each hospital, with lead officers

from a major purchaser in attendance. The meeting was acrimonious. North Manchester Hospital stated that its annual income from the unit was £1 million, of which one third covered fixed costs. This would mean a considerable financial shortfall for the next financial year if the cystic fibrosis service left. It was suggested they had already completed the contracts with the purchasers for the cystic fibrosis service for the next financial year and if the unit relocated they had decided to establish a rival service.

The most damaging effect of the conflict was on the cystic fibrosis team and patients. Most staff wished to transfer with the patients to South Manchester but when this move was blocked and the future of the unit became uncertain the staff were demoralised. There was hostility between paramedical staff in opposing camps and relationships between consultants were civilised but strained. The managerial approach from the North Manchester hospital was professional but non-communicative with the unit. Unit staff felt powerless.

Patients became concerned about their future having first been advised the unit would be relocated within the North Manchester hospital, then to South Manchester, and then this move was also blocked. The patients wanted to create considerable publicity to support the move. It was decided this approach would be counterproductive as there was considerable potential for misinformation on both sides.

There was concern that if the unit moved without an agreement the equipment purchased by charity might be forfeit. Although it had been specifically designated for patients, ownership belonged to North Manchester, who could rightfully keep the equipment. Some angry parents were even making plans to remove the equipment during the night if the unit had to move without an agreement. Furthermore, because transferring endowment funds between hospitals was uncommon, this process was unclear.

### Resolution

To make progress, various parties were consulted both formally and informally. The region vigorously supported the medical rationale for the transfer but stated that the two hospitals should resolve the issue between themselves. The then secretary of state for health, when approached for help, gave the same answer. The Cystic Fibrosis Trust, which had been instrumental in raising the £800 000 capital grant, expressed its concern to government that the award had been placed in jeopardy by the disagreement.

Had the purchasers been able to agree, they could have helped by forcing a decision. However, with at least 16 purchasers from the North West Region contracting separately for care, often for only a few patients, and with no lead purchaser, they were unable to reach a consensus.

Finally, on 5 August 1993, the chief executive of the Wythenshawe Hospital stimulated a new round of dialogue by writing to chief executives and purchasing consortia stating that a cystic fibrosis service would start in South Manchester under the leadership of the transferring cystic fibrosis consultant from North Manchester. Crucially, a postal ballot organised by the patients showed unanimous support for the move.

In early September the South Manchester Health Authority, concerned by the potential loss of the £800 000 grant, began building the new unit—before a final decision had been reached. At the end of November the unit (with great relief) moved between trusts into temporary ward accommodation at Wytheshawe Hospital, and then in May 1994 into the completed new building (figure).

The position regarding the transfer of staff was unclear. Would they have a transfer of rights or would they have to formally apply for their own jobs in South Manchester? Eventually it was agreed that the move would be considered under the Transfer of Undertaking and Protection of Employment Regulations. The senior physiotherapist was interviewed as the only candidate for her own post. The cystic fibrosis consultant resigned, took up a locum post to direct the relocated unit, and after six months was appointed without interview to the substantive post (agreed by the Department of Health).

Every patient transferred with the unit to Wytheshawe. The equipment moved with the unit at time of transfer, and after discussion with the Charity Commission the endowment funds were transferred six months later.

Four months after the move, North Manchester stated that it would be left with fixed costs. Furthermore, it claimed that it could provide the service for £300 000 per year less than South Manchester. Neither hospital could agree on a financial compromise. A lead purchaser, however, was appointed to arbitrate and closely inspected and accepted the costings with minor adjustments.

## Discussion

The reforms over the past seven years have created a climate of financial competition between trusts which has not always served the best interests of the patients. The requirement to balance the books at the end of each financial year in the face of rising costs and limited purchaser funding has led to conflict between trusts. Although it was in the best interests of the patients and staff to move, North Manchester seemed, understandably, unwilling to let go of a monopoly service with an accurate costing process<sup>1,2</sup> which generated an income.

The difficulty of resolving a damaging conflict between two competing providers highlights many of the current deficiencies that are inherent in the NHS reforms, based as they are on a political principle but untried in practice.

The element of competition between the two hospitals promoted a climate of fear, uncertainty, and demoralisation for the unit, patients, and managers. This was increased by the poor communication between the two hospitals. On the single occasion the two management teams consulted, they argued acrimoniously.

Purchasing was in its infancy at this time. Few purchasers approached the unit to ask whether the staff and patients wanted to be relocated, and they were unable to reach a collective decision.

During the time of the conflict “whistle blowing” was a controversial topic and national guidelines had not yet been published.<sup>3</sup> The patients and staff would have liked to have gone to the quality press but felt constrained.<sup>4</sup> On one occasion, architects contracted by South Manchester came to the unit for discussions

but were immediately asked to leave by North Manchester management. Communication between the paramedical staff of the two hospitals was discouraged by North Manchester.

The conflict dragged because there was no efficient arbitration process. The strength of the regional authority, with its days numbered, was declining, and North Manchester legitimately felt no need to comply with its suggestion that unit should relocate. No directives to arbitrate the transfer of specialist units between provider units existed. Central government stated that arbitration should be resolved by internal market discussions.<sup>5,6</sup> Of interest was the willingness of the government to forsake £800 000 of foreign capital investment through non-intervention.

Unresolved conflict produced a sense of isolation, job uncertainty, stress, and demoralisation among the staff. Patients were confused and were made angry by the fact that an acrimonious financial dispute could affect their medical future.

Although these events took place three years ago, history repeats itself. In Manchester it has taken years to resolve the transfer of neurosciences between trusts or paediatric services on to a single site. Currently the contraction of regional renal services from three to two sites is undergoing a lengthy and disputatious consultation process. Clearly, an effective arbitration mechanism for determining such disputes is urgently needed.

We are indebted to vigorous comments from M Brown, M Dodd, E Goodman, P Dando, and K Osborne.

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- 3 Smith R. Whistle blowing: a curse on ineffective organisations. Better management, not gagging, is the answer. *BMJ* 1992;305:1308-9.
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## Correction

*Should we screen for gestational diabetes? The case for screening for gestational diabetes*

An editorial error in this article led to a misspelling of the names of two of the authors (20 September, pp 737-9). The correct spellings are Jacqueline Castro-Soares and Anne Dornhorst.

## Endpiece

### Long term influence of diet in pregnancy

When George Abbot's Mother was with Child of him, she did long for a Jack or Pike, and she dreamt that if she did Eat a Jack, her Son in her Belly should be a *great Man*. Next morning, goeing with her Payle to the River-side, a good Jack accidentally came into her Payle. She took up the desired Banquet, dress'd it and devour'd it almost all herself, or very neare. The child was bred up a scholar in the Town, and by degrees, came to be Arch-Bishop of Canterbury.

John Aubrey (1626–97), *Brief Lives*,  
on George Abbott (1562–1633)